SPEC-TRANS APPLICATION

We appreciate your interest in Spec-Trans. The following application must be filled out legibly and completely. The release of information form must be filled out and signed by the passenger. The physicians form must be completed by a doctor, licensed health care provider, or licensed social caregiver familiar with your disability.

Once you have a completed application you may call the office, 806 378-3095, and setup a time to bring in the application and have an interview. Mailed, E-Mailed or Faxed applications will not be accepted. If you need a ride it can be provided too you free of charge both to and from ACT offices at 801 E 23rd Ave. You will receive a determination letter within 21 business days.

If you have any questions or need assistance completing this form, please call:

Phone: (806) 378-3095
TYY: Provide through Texas Relay Services at 7-1-1

This publication can be made available in alternate media formats and other languages by request.

For information on Spec-Trans policies please see the Spec-Trans Riders Guide.

Thank you for your interest in Amarillo City Transit.
Amarillo City Transit Spec-Trans Application

☐ New Application  ☐ Recertification

Section 1 General information:

Last Name: __________________________ First Name: _____________  Middle Initial __

Street address: __________________________________________________________

Name of Apartments: _____________________________________________________

Mailing address (if different): _____________________________________________

City: _____________________________ State: ___________  Zip: ___________

Phone: ___________________________  e-mail: _____________________________

Male: ☐  Female: ☐  Date of birth: _____________________  (Required)

Primary Language  ☐ English  ☐ Spanish  ☐ Vietnamese

Other (Please Specify) ___________________________________________________

Name and phone number of a relative or friend we can contact in case of emergency:

Name: ________________________________________________________________

Phone: ___________________________  E-mail: _____________________________

Relationship: _________________________________________________________

Do you have a caseworker?

Name: ________________________________________________________________

Agency: _________________________________________________________________

Phone: _________________________________________________________________

E-mail: _________________________________________________________________

May we contact your caseworker?  ☐ yes  ☐ no
What mobility equipment do you use?

- Manual wheelchair
- Cane
- Service Animal
- Power wheelchair
- White Cane
- Portable Oxygen
- Power scooter
- Leg Braces
- Crutches
- Walker
- Other: ________________________________

What limitations do you have?

Which of the following condition(s), if any, prevent you from using the Fixed Routes. Please check all that apply

- None
- Physical (Mobility)
- Physical (Other)
- Visual
- Mental Illness
- Brain Injury
- Intellectual Impairment
- Elderly/Frail
- Other: ________________________________

Briefly explain how your disability prevents you from using the Fixed Route Buses

______________________________________________________________________________

______________________________________________________________________________

Is your disability or condition  □ Permanent  □ Temporary

If temporary how long is the condition expected to last ____________________________

Do you currently use fixed route bus service? □ Yes  □ No

If yes, which routes? ____________________________________________________________

______________________________________________________________________________

If no, why are you no longer riding the Fixed Route buses ____________________________

______________________________________________________________________________
Are you prevented from traveling to or from a bus stop boarding location for one or more of the following reasons? (Check all that apply)

____ Inability to negotiate hilly terrain
____ Extreme sensitivity to climatic conditions
____ Allergic/environmental sensitivities
____ Hyper-fatigue, frailty
____ Night blindness
____ Inability to cross busy intersections
____ Inability to climb three 10-inch steps
____ Bus stop too far away
____ Other reasons. Please explain: ________________________________

Are you able to perform the following functions without supervision?

a) Find your way between familiar locations?
   Yes____ No____ Yes, with training ____

b) Signal the bus driver to get off at a familiar stop and get off the bus there?
   Yes____ No____ Yes, with training ____

c) At a bus stop served by more than one bus route, can you distinguish the correct bus to board and indicate your intention to board?
   Yes____ No____ Yes, with training ____

Are you able to perform the following functions without the assistance of another person?

____ Travel 200 feet (the length of a city block)
____ Travel ¼ mile (the length of 3 city blocks)
____ What is the maximum distance you can travel to get to a bus stop?

Are you able to wait outdoors for 10 or more minutes?
   Yes____ No____ Sometimes____
   If no, please explain_____________________________________________

Does your disability allow you to use the bus when you are feeling well?
   Yes____ No____

Does your disability allow you to use the bus when you are not feeling well?
   Yes____ No____

Are you able to cross the street or a busy intersection by yourself?
   Yes____ No____
   If yes, under what circumstances?___________________________________________
List three of your most frequent destinations, and how you get there?

<table>
<thead>
<tr>
<th>Destination or Street Address</th>
<th>Frequency of Travel</th>
<th>How do you get there now?</th>
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If you have an intellectual impairment or cognitive disability, are you able to: (check all that apply)

- [ ] Give name, address and telephone number upon request.
- [ ] Recognize a destination or landmark?
- [ ] Deal with unexpected situations or unexpected changes in routine
- [ ] Ask for, understand and follow directions
- [ ] Know what to do if the bus were to arrive late to pick you up

Consistent with Department of Transportation regulations, ACT will transport a mobility device with three or more wheels and its user so long as the lift can safely accommodate the size and weight of the device and its user on the lift and on the vehicle.

Spec-Trans has established curb-to-curb service as our basic service mode, however ACT is committed to ensure that passengers get from their origin to destination. Please check the one below that best describes your abilities.

- [ ] I am able to get myself to and from the curb without assistance.
- [ ] Because of my disability, I sometimes require assistance to/from the door.
- [ ] I require assistance, because of my disability, to/from the door on every ride.

If you require assistance beyond what the driver can give, you may bring a Personal Care Attendant (PCA) with you for free. The PCA can help you carry your personal items or groceries on the bus, lock or unlock doors.

Do you require the assistance of a PCA: [ ] yes [ ] no [ ] Sometimes

If yes, you must provide your own Personal Care Attendant – ACT does not provide personal care attendants.
By signing below, I hereby certify the information provided in this application is true, accurate, and complete.

I understand ACT requires applicants for Spec-Trans service to participate in an in-person interview.

I understand that providing false, incomplete, or misleading information, or refusing to participate in the in-person interview is grounds for denial of Spec-Trans service.

(Signature of applicant or responsible party) __________________________ (Date) __________________________

If the application was completed by someone other than the applicant, please provide the following:

Name of person completing application: (please print) __________________________

Relationship to applicant: ________________________________________________________

Address: ______________________________________________________________________

Phone: _________________________________________________________________________

Email: ________________________________________________________________________

I understand the rest of this application is to be completed by the Appropriate Health Care Provider that can be a Physician, Licensed Health Care Provider or a Licensed Rehab/Social Worker.

I hereby authorize the professional to provide information about my disability and abilities to use bus service to ACT and/or persons assisting ACT in determining my eligibility for Para-transit Service. I understand that this information will be used for the purpose of determining my eligibility for Para-transit Service and that the medical information about my disability will be kept confidential.

(Signature of applicant or responsible party) __________________________ (Date) __________________________

(Please Print Your Name) ________________________________________________
Section 2 Health Care Provider Certification

Dear Health Care Provider:

The Americans with Disabilities Act and its implementing federal regulations established categories of persons who are eligible to receive paratransit services complementary to fixed-route bus services. The three categories of persons with rights to complementary paratransit are:

1. Persons who, because of their disability, cannot independently board, ride and/or disembark from an accessible vehicle.

2. Persons who, because of their disability, cannot use vehicles without lifts or other accommodations.

3. Persons who, because of their disability, cannot get to or from a boarding or disembarking location.

Any individual is to be certified as ADA paratransit eligible if there is any part of the Transit System that cannot be used or navigated by that individual because of a disability. **A disability alone does not qualify an individual for Spec-Trans service. Eligibility is not based on the applicant’s disabilities, but on their functional capabilities to use the accessible fixed route bus service.**

The information requested from you on the following pages will allow Amarillo City Transit to obtain the information necessary to establish eligibility of the applicant. Thank you for your assistance.
To Be Completed By the Appropriate Health Care Provider

(Please Print or Type)

Please Check One:
___ Physician
___ Licensed Health Care Provider
___ Licensed Rehab/Social Worker

Applicant’s Name _______________________________________________________
Last, First, Mid. Initial

Medical diagnosis of condition causing disability:________________________________________
_____________________________________________________________________
_____________________________________________________________________

Is the condition permanent?
Yes____ No____ If not, expected duration:_____________________

Does this disability prevent the applicant from utilizing the fixed route services (regular bus service)? If yes, please describe in detail. ________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
___________________________________________

Please answer all of the following questions.

The following information will be used to ensure Amarillo City Transit can make an accurate analysis of the applicant’s trip requests.

Does the applicant use any of the following mobility aids? (Check all that apply)
___ Cane    ___ Power Chair    ___ Communication Board
___ White Cane ___ Large Power Chair ___ Picture/Alphabet Board
___ Walker    ___ Power Scooter    ___ Portable Oxygen Supply
___ Crutches ___ Manual Chair    ___ Personal Care Attendant
___ Leg Braces ___ Service Animal ___ Other: __________________


1. Can the applicant climb three 10-inch steps with assistance?
   Yes____ No____

2. Can the applicant wait outside without support for 10 minutes?
   Yes____ No____

3. Is applicant on dialysis?
   Yes____ No____

4. Does the applicant have a hearing impairment?
   Yes____ No____

5. Is the applicant able to give addresses and phone numbers upon request?
   Yes____ No____

6. Is the applicant able to recognize a destination or landmark?
   Yes____ No____

7. Is the applicant able to deal with unexpected situations or unexpected changes in routine?
   Yes____ No____

8. Is the applicant able to ask for, understand, and follow directions?
   Yes____ No____

9. Is the applicant able to safely and effectively travel alone through crowded and/or complex facilities? Yes____ No____

**If the applicant has a visual impairment:**
Visual acuity with best correction: Right Eye ___________ Left Eye ___________
Both Eyes ___________

Visual Fields: Right Eye ___________ Left Eye ___________
Both Eyes ___________
Please describe any other disability or effect that prevents the applicant from using the regular bus service.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

******************************************************************************

Based upon my professional knowledge of the applicant, I certify that the preceding information is true and correct.

Name of Health Care Provider (Please Print) Office Phone Number

Office Street Address City State Zip Code

State License Number (Complete if Applicable – Must be Current)

Signature ___________________________ Date ___________